

# THE MEDICAL NEWS AND LIBRARY.

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<b>CLINICS.</b>		considerable doubt upon the absolute correctness of the latter part of this proposition, or at least show that this rule is not without an exception.
<b>CLINICAL LECTURES.</b>		The first case was that of a healthy-looking sailor, aged 25, who was admitted into No. 11 ward on February 21. Five years ago he had been laid up with a sharp attack of gonorrhœa, and since then had suffered from a gradually increasing stricture. Several unsuccessful attempts had been made by medical men to pass instruments into his bladder; after each attempt he had shivered and felt unwell for one or two days. He was kept in bed for three days, the bowels freely opened with castor oil, and on the evening of February 24 a full dose of Dover's powder was administered.
<i>Clinical Lecture on Two Cases of Death after Holt's Operation.</i> By R. W. TIBBITS, M.B., M.R.C.S., Surgeon to the Bristol Royal Infirmary, Lecturer on Surgery at the Bristol Medical School.		February 25. Holt's instrument was easily passed, and the stricture—a slight
GENTLEMEN: Those of you who take an interest in the treatment of stricture of the urethra are certain to read Mr. Barnard Holt's very interesting work upon this subject. You will see that he sums up the great advantages to be derived from his method of forcible dilatation or rupture in the proposition—"that the process is facile, speedy, prompt in its effects, and free from every danger—immediate or remote." I am afraid that the two cases I intend to bring under your notice this morning must throw		

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one—split with the largest-sized dilator. Afterwards No. 11 catheter was introduced into the bladder.

26th. Patient seemed perfectly well. Had not shivered after the operation, and passed his urine in a full stream, with slight pain.

27th. Still going on well. No. 10 catheter passed easily, causing little pain.

28th. Twenty-two hours after the passing of No. 10 catheter, and seventy hours after the operation, he was suddenly seized with a severe rigor, which lasted for two hours. He then perspired freely. Countenance extremely anxious-looking. Complained of much pain in his head and back. No tenderness in the perineum or over the abdomen. No albumen or pus in the urine. Nothing to be detected with the stethoscope. Pulse 120; temperature 101.60.

March 1. Complained of feeling very ill. No recurrence of the rigor. No pain anywhere. Tongue dry and brown. Morning: Pulse 136; temperature 105.0. Evening: Pulse 128; temperature 103.60.

2d. Evidently much worse. Complained of no pain or tenderness anywhere. Urine scanty, but free from albumen. Nothing to be detected with the stethoscope. Morning: Pulse 136; temperature 104.20. Evening: Pulse 116; temperature 104.0.

3d. Perspiring freely. Could not be roused sufficiently to understand the questions asked him. Extremities congested. A dark purple petechial-looking rash had appeared over the whole of the body, especially on the chest, where it was very thickly distributed. Tongue dry and brown. Pulse 160; temperature 104.50.

From this time he gradually passed into a state of coma, and died on the following night at a quarter-past one o'clock, the temperature rising to 107.60 fifteen minutes before death.

*Post-mortem Examination* (thirty hours after death).—Lungs congested posteriorly; extreme staining of inside of heart and bloodvessels; liver healthy; spleen enlarged, and broke down into a pulp when cut; kidneys presented numerous hemorrhagic spots, varying in size be-

tween a pin's head and a small pea—many of these showed signs of softening in their centre; bladder healthy, walls rather hypertrophied. Around the seat of stricture, at the junction of the spongy and membranous portions of the urethra, there was a slight extravasation of blood; the mucous membrane over this part was perfectly smooth—there was no apparent rupture of it. The prostatic veins were considerably obstructed, and one of them was blocked with a firm clot for about an inch and a half.

This, gentlemen, is one case. Let me now briefly read you the notes of the second one, which appeared in our post-mortem room yesterday, and which you have all had an opportunity of observing:—

D. S., aged 46, a muscular Irishman, was admitted into No. 9 ward on December 18. He told us that he had only noticed that his urine came in a small stream during the last two years; that on several occasions he had had small sized instruments passed, and that once or twice he had shivered after their passage, but this was not the rule.

December 14. A No. 5 sound was attempted to be passed, but only for a short time, as the stricture bled at the slightest touch of the instrument.

15th. Had suffered no inconvenience from the attempted passage of the sound. Ordered ten grains of Dover's powder at night and half an ounce of castor oil the next morning.

16th. Holt's instrument was passed with little difficulty through a stricture in the membranous part of the urethra, which was split with the largest-sized dilator; one or two drops of blood following the operation. Ordered thirty minims of tr. opii and two ounces of brandy to be taken in hot water. In the evening he passed his water freely with little pain.

17th. 4 A. M.: Whilst at the closet was seized with a severe rigor, which lasted for about two hours. 9 A. M.: Temperature 102.20; pulse 120. Ordered brandy and an opiate draught. 12 noon: Temperature 102.0; pulse 130, weak; extremities cold and congested. Ordered five grains of carbonate of am-

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monia every two hours. 2 P. M.: Pulse weaker. Ordered three ounces of brandy in hot water. 5 P. M.: In much the same condition. Brandy to be repeated. 9 P. M.: Temperature 100.2°; pulse 130. Brandy and ammonia to be continued: hot-water bottles to be applied to extremities.

18th. 9 A. M.: Temperature 100°: pulse uncountable. To continue brandy. 2 P. M.: Temperature 101.2°; pulse imperceptible at wrist; extremities mottled purple. Has passed no water during the last twenty-four hours; bladder not distended. Patient perfectly sensible, but restless. Ammonia to be discontinued; half an ounce of brandy every fifteen minutes; to be dry-cupped over loins and to have hot fomentations of infusion of digitalis applied over the abdomen.

From this time his condition changed but little. He passed a small quantity of water at about 6 P. M., and remained sensible to within a short period of his death, which occurred at 3 A. M. on the following morning—sixty-two hours after the operation, and forty-eight after the first rigor.

*Post-mortem Examination* (ten hours after death) —Moderately firm old pleuritic adhesions on both sides of the chest; lungs healthy, but congested at bases; heart and its valves healthy—a small quantity of clot and fluid blood in each cavity—no clot in the pulmonary artery; intestines and peritoneum healthy; liver to some extent congested, otherwise perfectly healthy; spleen healthy; kidneys healthy, not even congested. The bladder contained about six ounces of urine; walls slightly hypertrophied; mucous membrane healthy, and not congested, except for a patch about the size of sixpence at the posterior part of the neck of the bladder; the tissues under this were also congested for the depth of about the eighth of an inch. The urethra was slightly congested along its whole tract, and at the juncture of the spongy and membranous portions there was a patch of deep congestion, showing the seat of the stricture. There was slight extravasation of blood

into the tissues around this for the depth of about the eighth of an inch. The mucous membrane over this point, examined under the microscope with a two-inch lens, showed no sign of rupture.

It has seldom been my duty to draw your attention to cases of so painful an interest as the two I have just related. Those of you who saw the first patient will recollect what a fine healthy-looking man he was. You will also remember, that in the operation-room I mentioned that it was the slightest case of stricture that I had ever performed forcible dilatation upon. It may be said that in this instance the passage of the catheter on the second day after the operation was the cause of the mischief; but then the subsequent passing of a catheter follows as a necessity upon this method of treatment. In the second case no such question can arise. This man, with all the organs of his body healthy, died in sixty-two hours from the undoubted effects of the operation.

There was a certain amount of resemblance between these two cases. In each the first symptom was a severe rigor, coming on many hours after the operation, and in each there was the same dusky congested appearance of the extremities. Very little either was there to be detected during life, and still less in the post-mortem examinations; for I look upon it as probable that the deep-red condition of the inside of the heart and large vessels in the first case was due to a considerable extent to the effects of decomposition. But the hemorrhagic spots in the kidneys of the first patient were exactly similar in appearance to that which you sometimes see in well-marked pyæmia. Moreover, during life, the symptoms and appearance of these patients closely resembled what we see in the worst cases of septicæmia, following after other operations or injuries which sometimes, but fortunately very rarely, occur in the wards of our Infirmary. Therefore I should put down the cause of death in both instances to blood-poisoning.

The practical lesson I wish you to learn is, that in performing any operation upon the urethra you cannot be too careful.

When the patient's history points to the stricture being a bad one, or more especially should he habitually have suffered from rigors after the passing or attempted passing of an instrument, let me urge upon you the advisability of insisting upon at least twenty-four hours' complete rest before you attempt to do anything. It has always been my rule to do this; and for two reasons—first, you will find it much easier to pass an instrument through a bad stricture if your patient has been kept quiet for some time; secondly, I believe that previous rest often obviates the occurrence of subsequent unpleasant symptoms, for I have more than once found that patients who had always suffered inconvenience from the passage of an instrument would stand considerable manipulation with impunity, previous rest having been insisted upon. At any rate, should mischief result, you will have the satisfaction of knowing that all rational means had been taken to prevent it. Holt's operation is one you have seen me perform moderately frequently, but never without having kept the patient in bed for at least forty-eight hours.

Mr. Holt claims for his operation that cases of stricture treated by this method show less tendency to contract than after any other plan of treatment. My experience relates only to strictures situated in the neighbourhood of the membranous part of the urethra; but it is decidedly in favour of this assertion. At the same time, as a rule, unless a full-sized instrument is afterwards passed with tolerable regularity, you are running your patient to unnecessary risk; for to a certainty will the diseased tissues again contract.

There is one more point of very special interest that these cases help to demonstrate. I mean what actually occurs when you rapidly force the dilator through the stricture. Mr. Holt advances the proposition that the diseased submucous tissue is alone split, and that the mucous membrane is simply dilated. This is a matter of considerable importance, because, with any considerable wound of the mucous membrane of the urethra, there would be a risk of infiltration of

urine being the result, though I believe this risk would be slight. We particularly examined both these cases, with the view of obtaining information on this point, and undoubtedly they go towards proving the correctness of Mr. Holt's supposition; but we must bear in mind, that during the time these patients lived after the operation, a certain amount of rupture might have healed. Still, they certainly seem to prove that, at any rate when the stricture is not a bad one, the injury, if any, that is done to the mucous membrane is of the slightest.

With these two cases before us, it may perhaps suggest itself to the minds of some of you to ask—Why continue to perform the operation? You cannot learn too early that cases of stricture, as a class, are some of the most troublesome and difficult that you will have to deal with, and also that no method of treatment is perfectly free from danger, for death has more than once resulted from the simple passing of a catheter. There are also persons who will not submit to the tedious treatment by gradual dilatation. Specially have I found this amongst the lower classes, with whom time is of importance. These people will remain under treatment till the stricture is partially relieved, and then cease to attend, to come back again in a few months' time worse than ever. But even under these circumstances you would not be justified in performing Holt's operation, if the risk to life from it is considerable, unless the advantages to be derived from it are far more considerable. But what is the increased amount of risk? Sir H. Thompson, in his lectures on "Diseases of the Urinary Organs," lays no stress upon this point, neither is it referred to by many of our best surgical authorities. Moreover, the results published by Mr. Holt are extremely favourable; therefore we have a right to assume that the cases we have this morning considered are very exceptional. My experience of the advantages of the operation in successful cases is decidedly satisfactory; but unless the patient afterwards submits to the periodical passing of a full-sized instrument, the

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stricture will again to a certainty contract, and the operation will have been useless.

In treating all ordinary cases of stricture let me advise you, as a rule, to adopt first of all the simplest method at your disposal, and fairly try the plan of gradual dilatation, reserving Holt's operation for the more severe cases, or for those patients who will not submit to lengthened treatment. Remember, also, that there are certain persons whose constitutions resent any interference with their urethra, and who will tell you that they nearly always suffer from a rigor after any attempt to pass a catheter. It will behoove you in such cases to be especially careful. —*Medical Times and Gazette*, August 2, 1873.

#### HOSPITAL NOTES AND GLEANINGS.

*Aneurism of Thoracic Aorta benefited by Large Doses of Iodide of Potassium.*—Under the care of Dr. DYCE DUCKWORTH, at St. Bartholomew's Hospital, T. H., aged 47, a clerk, having served twenty-two years in the army, and twenty years of his time in India, applied in October, 1872, for relief from an aortic aneurism. He was first seen by Dr. Lauder Brunton. The patient was a stout well-built man, of florid complexion, with dark-brown hair; height, five feet six inches. There was no history of intemperance, or syphilis, or of bodily strain. Three years ago he first began to complain of pain across his chest, and had advice. He alleged that at that time there was a pulsating tumour, of the size of an egg, above and towards the left side of the sternum. It used to be visible to bystanders as moving his clothes. For six months he was under treatment, and the tumour reduced in size. He was able to resume his work, and has continued it since, with the exception of a few days. No further advice was sought, and no treatment employed, till October, 1872. At that time there were fullness and pulsation over the upper and left sternal region, with an area of dulness to percussion of one and a half by one and a half inches. There was a prolonged first sound over the cardiac region, no *bruit* being audible

over the fullness. Pulsation was very feeble in the left carotid and brachial arteries. The left pupil was smaller than the right; the voice was hoarse. The treatment consisted of quinia till Christmas, 1872. At that time the cardiac sounds were more loudly heard over the tumour than over the præcordia, and there was a prolonged rough systolic blowing. The left pulse was much smaller than the right. The patient was able to act as a clerk, but suffered a good deal of pain in his chest and back, especially at night. At this time he was ordered ten grains of iodide of potassium three times a day, and morphia and chloral in a draught at bedtime each night. In January, the quantity of iodide was increased to fifteen grains for a dose. Under this treatment there was gradual improvement in all the symptoms. In April he was able to sleep without the anodyne, and he could take a fair amount of exercise daily. In May, he reported that his voice was at times natural, and that occasionally his pulse was fuller in the left wrist. He had no pain in the chest, slept well, and was doing duty as a storekeeper. The left pupil remained small; the pulse was hardly felt in the left radial artery; there was dulness on percussion for about two inches square in the region of the tumour to the left of the manubrium, and under the left clavicle. There was slight heaving pulsation over the area of the tumour; a very faint distant murmur, systolic, and of low pitch, was audible over the dull region; no dulness and no murmur was detected posteriorly. The patient continues to take iodide of potassium regularly.

*Remarks by Dr. Dyce Duckworth.*—The points of interest in this case are the following: The first is, the occurrence of aneurism in a soldier who had served long in India, and had, therefore, been subjected to the strain placed upon his circulatory system by improper clothing in that climate. (Thanks to the labours of Parkes and others, this is no longer the case in the British army.) The case is one of a class in which the course of the aneurism is very chronic. The aneurism illustrates a point which is not unfrequently to be



observed, but which is rarely commented upon, viz., the tendency of sacculated aneurisms to change their relation to surrounding parts. In the history of some of these tumours it is found that certain portions are more prominent at one period than at another. This is especially to be observed in such thoracic aneurisms as point through the chest-wall; hence the pressure-signs may vary from time to time. These changes are probably due to the peculiar depositions of fibrin upon the walls of the tumour. When this patient was first seen, there was no prominent pulsating swelling, such as he described to have existed about three years previously.

The marked benefit resulting from the iodide of potassium, when compared with the treatment by quinia, could escape the attention neither of patient nor of physician; and this case illustrates the good results of that plan of therapeutics, which was first recommended by Dr. Chuckerbutty, of Calcutta, and Dr. G. W. Balfour, of Edinburgh. In the case above described, no special precautions were enjoined, either as to diet or the recumbent posture; and Dr. Balfour's system of treatment includes a restricted allowance of food and rest. We have no knowledge as to the nature of the changes wrought in such a case by the iodide of potassium. It is not known to induce coagulation of fibrin; indeed, one would naturally regard the drug as one likely to diminish any tendency to hyperinosis. Dr. Arthur Gamgee has suggested that the good results are due to an action exerted upon the vaso-motor nervous system; and he believes that the present condition of blood-chemistry throws no light upon the subject.—*Brit. Med. Journal*, Aug. 23, 1873.

**Treatment of Aortic Aneurism by Galvano-puncture.**—At University College Hospital on Tuesday, Mr. MARCUS BECK operated by galvano-puncture on a very rapidly growing aneurism of the descending aorta. The patient, a man aged about 40, had only suffered from pain and dyspnoea about a month, and a pulsating tumour had appeared in the lower dorsal

region a few days only before admission. During the short time the patient had been in the hospital, the tumour had been daily increasing in size, the neighbouring ribs becoming rapidly eroded. Mr. Beck introduced the wires about an inch apart through the most prominent part of the tumour, and passed the current between them for an hour and a quarter. The immediate effects of the operation were decidedly encouraging. The pain was much diminished, and the expanding impulse also lessened. The improvement still continued this (Thursday) morning. There was rather less bulging of the lower part of the chest, as well as diminished thrill. We shall report the further progress of the case next week.—*Brit. Med. Journ.*, Sept. 6, 1873.

**Senile Gangrene of the Foot cured by the Oxygen Bath.**—Hôpital la Pitié. Under the care of Dr. LEON LARRE. This case is eminently illustrative of the good effects of the oxygen bath in cases of senile gangrene. The patient was a man of about fifty. The case began with atrocious pain in the toes of the left foot, and the large toe and the next one soon assumed a dark-red colour, the patches extending in small ribbon-like lines to the articulation of the foot and leg. It was impossible to mistake the beneficial effects of the application of oxygen—the symptoms were almost instantaneously amended. The pain ceased immediately. On removing the oxygen, experimentally, the pain returned, and the other symptoms got worse. An eschar, formed on the large toe, has now fallen, and all that is at present left of the disease is a slight pinkish hue of the two toes, extending a little up the foot.—*Lancet*, Aug. 2, 1873.

## MEDICAL NEWS.

### DOMESTIC INTELLIGENCE.

**Circumcision for Congenital Phimosis with the Galvanic Cautey.**—In order to avoid the possibility of dangerous hemorrhage following the ordinary operation of circumcision, F. DAWSON (*Am. Journ. of Obstet.*, Aug. 1873) determined to make use of the galvanic cautey in a case

brought to him for operation. He noosed the prepuce in a loop of fine platinum wire connected with his battery, and then removed it by constriction, after which two or three strips of the mucous membrane with scissors enabled him to retract and liberate the glans. The results of the case satisfactorily demonstrated the success of this mode of operating, which, in Dr. Dawson's opinion, commends itself for trial in other cases.

Dr. Dawson claims the following advantages for this method: Entire avoidance of immediate or secondary hemorrhage; quickness of the operation over other methods, for when the wire is fully heated, the removal of the prepuce should be but momentary; avoidance of the necessity of restraining the patient as to exercise, etc.

In his next case Dr. Dawson intends to operate with the cautery knife instead of the loop.

*Morphia in Acute Uræmia.*—Dr. ALFRED L. LOOMIS (*Medical Record*, Aug. 1, 1878), in a recent paper on acute uræmia, discusses the propriety of administering morphia in full doses hypodermically to patients with acute uræmia, and the effects which follow such administration. The histories of ten cases which he narrates, lead him to the following conclusions:—

*First.* That morphia can be administered hypodermically to some if not to all patients with acute uræmia, without endangering life.

*Second.* That the almost uniform effect of morphia so administered is—1st, to arrest muscular spasms by counteracting the effect of the uræmic poison on the nerve-centres; 2d, to establish profuse diaphoresis; 3d, to facilitate the action of cathartics and diuretics, especially the diuretic action of digitalis.

Thus morphia, administered hypodermically, becomes a powerful eliminating agent.

The rules which are to govern its administration are as yet not well defined. My own experience would teach me to give small doses at first—not to exceed ten minims. If convulsions threaten, and a small dose does not arrest the muscular

spasms, it may be increased to twenty minims, and the hypodermics may be repeated as often as every two hours. It must be given in sufficient quantities to control convulsions; neither the contraction of the pupils nor the number of the respirations is a reliable guide in its administration.

*Hypodermic Injections of Morphia in Autumnal Catarrh.*—Dr. CARSON, of Cincinnati, at a late meeting of the Cincinnati Academy of Medicine, stated (*The Clinic*, Sept. 20, 1873), that in a case of hay fever he had adopted the suggestion of Dr. Moss, of Philadelphia (*Am. Journ. of Med. Sci.*, Jan. 1873, p. 275), and gave the sulphate of morphia, gr. one-fifth, hypodermically. The symptoms were absent for three days, and then returned. He again repeated the operation with the same results, but the cough still continued. In this case the eyes were swollen and red, the membranes of the nose congested, and violent sneezing was almost constant. He again administered the hypodermic injection of morphia with relief. He suggested a trial of this agent in these cases.

*Rules for Feeding Babies.*—The following rules are extracted from an essay recently read before the Public Health Association, by Dr. A. JACOBI, of New York:—

*I. Nursing Babies.*—Overfeeding does more harm than anything else. Nurse a baby of a month or two every two or three hours. Nurse a baby, of six months and over, five times in twenty-four hours, and no more. When a baby gets thirsty in the mean time, give it a drink of water, or barley-water. *No sugar.* In hot weather—but in the hottest days only—mix a few drops of whiskey with either water or food, the whiskey not to exceed a teaspoonful in twenty-four hours.

*II. Feeding Babies.*—Boil a teaspoonful of powdered barley (grind it in a coffee grinder) and a gill of water, with a little salt, for fifteen minutes; strain it and mix it with half as much boiled milk, and a lump of white sugar. Give it lukewarm, through a nursing bottle. Keep bottle and mouth-piece in a bowl of water when

not in use. Babies of five and six months, half barley-water and half boiled milk; with salt and white sugar. Older babies more milk in proportion. When babies are very costive, use oatmeal instead of barley. Cook and strain. When your breast-milk is half enough, change off between breast-milk and food. In hot summer weather try the food with a small strip of blue litmus-paper. If the blue paper turns red, either make a fresh mess or add a small pinch of baking soda to the food. Infants of six months may have beef-tea or beef soup once a day, by itself, or mixed with other food. Babies of ten or twelve months may have a crust of bread and a piece of rare beef to suck. No child under two years ought to eat at your table. Give no candies, in fact nothing that is not contained in these rules, without a doctor's order.

III. *Summer Complaint.*—It comes from over-feeding and hot and foul air; never from teething. Keep doors and windows open; wash your children with cold water at least twice a day, and oftener in the very hot season. When babies vomit and purge, give nothing to eat or drink for four or six hours, but all the fresh air you can. After that time you give a few drops of whiskey in a teaspoonful of ice-water every ten minutes, but not more until the doctor comes. When there is vomiting and purging give no milk. Give no laudanum, no paregoric, no soothing syrup, no teas.—*Medical Record*, Sept. 15, 1873.

*A National University.*—At a meeting of the National Educational Association, held at Elmira on the 5th, 6th, and 7th of August last, President ELLIOT, of Harvard University, read a sensible and conclusive paper on this subject. "After detailing at considerable length the history of the action of the association on this subject in 1869, he proceeded to examine the two bills which were brought before Congress in 1872 and to discuss the true policy of the government upon this matter. Under the first head it was shown that although the association had from time to time appointed committees to consider the subject, yet it had never committed itself to any defi-

nite policy, and the bills introduced into Congress for the establishment of such a university had been almost solely the work of individuals, and without authoritative support. Passing to consider the bills introduced for the creation of a university, they are found to be crude in conception, cumbrous in the provision of the machinery of administration, and impracticable of execution. But even if these essential defects could be remedied, it is no part of the duty of government to maintain a magnificent university. 'The general notion that a beneficent government should provide and control an elaborate organization for teaching, just as it maintains an army, a navy, or a post-office, is of European origin, being a legitimate corollary to the theory of government by divine right.' But the arguments in support of this view prove a great deal too much. For if they have the least tendency to persuade us that government should direct any part of secular education, with how much greater force do they apply to the conduct by government of the religious education of the people. There is one broad reason why government should not establish and maintain a university. If the people of the United States have any special destiny and peculiar function in the world, it is to try to work out under extraordinarily favourable circumstances the problem of free institutions for a heterogeneous rich, multitudinous population, spread over a vast territory. We indeed want to breed scholars, artists, poets, historians, novelists, engineers, physicians, jurists, theologians, and orators; but first of all we want to breed a race of independent, self-reliant freemen, capable of helping, guiding, and governing themselves. Now the habit of being helped by government, even if it be to things good in themselves—to churches, universities, and railroads—is a most insidious and irresistible enemy of republicanism, for the essence of republicanism is self-reliance.—*The College Courier*, August 16, 1873.



## FOREIGN INTELLIGENCE.

*Treatment of Wounds.*—Mr. JOHN WOOD, in his Address in Surgery delivered before the British Medical Association at its recent meeting said, "that after frequent trials, I have come to consider that a plan comprising the free use of Chassaignac's drainage tubes passing from the surface of the wound, or from its interior if deep and sinuous, and with their outer extremities imbedded in cotton wool or oakum, well permeated with MacDougall's or Calvert's powder, or other disinfectant and absorbent of discharges; the surface of the wound washed over after bleeding has ceased with a mixture of solutions of chloride of zinc and carbolic acid or sulpho-carbolate of zinc; the same solution to saturate the lint, applied in the same way as in water dressing, and enveloped in thin gutta-percha tissue, the whole supported by strapping and a light bandage, affords the readiest, lightest, coolest, and the most generally useful application of the antiseptic method. An outer envelope of cotton wool or oakum, and dressing every day after the first opening of the primary dressing, complete a method from which I have obtained as good results as from any other that I have tried, and, what is perhaps important, I have found it less difficult to insure its being properly carried out.

"I believe that cases of recovery frequently occur under other methods, or no methods, and that at least as much depends upon the age and reparative power of the patient, the amount of blood poison formed or absorbed, and the general conditions of the atmosphere as upon any system of treatment whatever.

"I attach much importance, as I have said, to free drainage in dressing wounds, and when these are made by the surgeon a good deal more may be done to favour this by a judicious choice of the direction of the incision in resections, etc., and the position of the flaps, etc., in amputations. The plan of making a puncture in the popliteal space, proposed by Mr. Jonathan Hutchinson in excision of the knee-joint, is one which illustrates my meaning. The wound should if possible be made to slope

towards that part which is most dependent when the patient is laid in bed. In amputations of the thigh, I think for this reason that the circular operation is most objectionable, on account of its forming a hollow funnel-shaped wound, which, in the necessarily raised position of the stump upon a pillow, holds the discharge like a bucket slightly tilted. Very good drainage is accomplished in the late Mr. Teale's excellent plan of a single square anterior flap. I have practised Mr. Teale's method with the best results in the leg and forearm; but for other reasons, I prefer in the thigh an oblique double flap, with the outer end of the incision placed lower than the inner, and the front flap placed somewhat outside the limb, and longer than the hinder. After many trials, I am quite convinced that this both gives the most complete drainage, prevents the bone protruding, and makes a very shapely and serviceable stump, with the cicatrix placed well behind the point of pressure. Another important point bearing on this matter in favouring the escape of discharges from the interior of a wound, lies in the manner of securing the arteries. When an artery is twisted in, as in the ancient Roman system, revived by Amussat and Velpeau, and lately tried by Mr. Cooper Forster<sup>1</sup> and Mr. Bryant,<sup>2</sup> or when it is secured by a pin or wire, as advocated by the late Sir James Simpson, and practised at Aberdeen and elsewhere; or when it is secured by an antiseptic catgut ligature, cut off short on the vessel, as revived by Professor Lister, and tested by Mr. T. Holmes, the theory is, that the wound should heal in the deeper parts as well as in the more superficial, by the direct adhesive process. But this, in the amputation of an extremity, or a large resection, is not the rule, and moreover, in large cities is not usual. Now the parts that are most disposed so to heal are the smoothly cut, self-adapting and vascular tegumentary structures, and these sometimes close up by adhesion, leaving interior cavities, especially about the bone, and between the muscles,

<sup>1</sup> Trans. Clinical Society, 1870.

<sup>2</sup> On the Torsion of Arteries, *Medico-Chirurgical Transactions*, li. p. 199.

containing decomposing blood or pus, which afterwards accumulate, burrow, give trouble, and delay the cure, or cause by pyæmia the death of the patient. To prevent this subsequent inconvenience, after experience of it, seems to be the only rational explanation of the continental method still employed of stuffing the whole wound with charpie, so as to insure healing from the bottom, which seems so strange to our notions. If we could be quite sure that by torsion, metallic or antiseptic ligatures, we could secure complete adhesion throughout, the case would be made very much stronger in their favour. But this is certainly the exception, and not the rule. There are other elements at work influencing this, even more powerful than the local treatment. Now I believe with my colleague, Sir W. Fergusson, that so long as we have this want of entire union, ligature threads may have the advantage of keeping open channels for the escape of discharges from the close neighbourhood of the tied arteries, the accompanying veins of which are frequently the sources of effusions of blood after the wound is dressed, and these afterwards clot, and may putrefy. The ligature threads I usually have well steeped in carbolized oil, and saturated so as to be unable to absorb discharges, and so utilized to spread around an antiseptic influence. Sometimes in deep narrow wounds I place them within or alongside of a drainage tube. They can thus be made into channels for the introduction of antiseptic agents to the deeper parts, and this consideration may add to the much greater sense of security given to the surgeon's mind on leaving his patient, arising from the use of a safe knot and a string to remove it by when it has performed its work. There is one point in the section of flaps which may I think have influence sometimes upon the introduction of pus or septic matter into the cut veins. When these are cut obliquely with the face of the flap, they are opened in a large conic section in the shape of a pen, and left, when placed on the underlying flap, in an attitude well adapted for receiving and conducting into their interior pus and putrid discharges which gravitate from the

surrounding hollow and often funnel-shaped sides. To obviate this, I invariably, after a flap amputation, cut off the larger veins transversely."—*Brit. Med. Journal*, Aug. 9, 1873.

*Injection of Iodine during Acute Inflammation.*—Dr. MENZEL, Senior Surgeon to the Trieste Civil Hospital, has published an article in the *Gazetta Medica Lombardia* of July 19, on "The Injection of Iodine into Tissues the seat of Acute Inflammation." He observes, that while during the last ten years various articles have been injected into the substance of tissues affected with different forms of chronic disease, he is not aware of any instances in which such practice has been pursued during the existence of acute inflammation. Repugnance has been felt to injecting tissue, the seat of acute phlogosis, with substances possessing more or less power of inducing inflammatory action. His object in the present paper is to show that such practice may nevertheless be attended with great benefit; and, although he certainly is able to adduce but very slight evidence in favour of this view, we may as well lay it before our readers. During last spring diphtheria prevailed severely in Trieste, defying the various remedies employed, such as cauterization, the chlorate and permanganate of potash, carbolic acid, quinia, etc. Most of the children brought to the hospital were already affected with excessive bilateral tumefaction of the cervical glands, the lymphadenitis pursuing a rapid course in diphtheria, and inducing a far greater amount of swelling than is observed in ordinary catarrhal tonsillitis. In the author's opinion, the frequent inefficiency of caustics arises from the circumstance that the morbid agent has been transported from the parts accessible to their action (as the tonsils, velum, etc.) to the glands of the neck, and thence into the circulation. Under such circumstances the caustics will only act by limiting the local gangrene; and, although the tonsils may be freed, the ganglionic intumescence and the general symptoms persist, and the patients succumb. The question arose whether the "parenchymatous injection"

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of iodine might not arrest the local destructive process, and at the same time, by its absorption, exert a favourable effect on the progress of the disease. The first case in which it was tried seemed to realize the most sanguine expectations. A girl, aged 6, when brought in, had been ill two days, and the tonsils were so swollen as to be in intimate contact with each other. The removal of the white membrane which covered them exposed an ulcerated surface. Beneath the angle of the jaw on each side were two or three glands the size of walnuts, of an elastic consistency, and very tender to the touch. Each tonsil, by means of a Pravaz syringe, was injected with four drops of Lugol's solution. Next day the tonsils were found reduced to their normal dimensions, and the glandular swellings were hardly perceptible. In other cases the iodine was injected in part into the tonsil and in part into the arch of the palate and the velum, and was repeated daily until the tonsils were reduced. Of seven children so treated three recovered; and although two died, and the other two, not being heard of again, probably also died, yet, as the epidemic was a very severe one, even this amount of success is not to be despised. Dr. Menzel, however, admits, that he has not brought much material forward, but he observes that the means are quite innocuous, and are productive of no local inconvenience.—*Med. Times and Gaz.*, Aug. 2, 1873.

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*On a New Method of Determining the Presence of, and Recovery from, True Ring-worm.*—At the recent meeting of the British Medical Association, Dr. DYCE DUCKWORTH called attention to the action of chloroform upon the infected hairs in cases of tinea tonsurans. It was shown that this agent caused the hairs to become white or slightly yellow in colour, and thus to be distinctly mapped out and easily distinguishable from surrounding healthy hairs. The causes of the change were briefly discussed, and the particular phases of the disorder suitable for this application were pointed out. The effect of chloroform on patches of favus, tinea versicolor, melasma, and alopecia areata

was likewise discussed. It was shown that no other reagent, so far as was known, possessed the peculiar properties of chloroform in affecting parasitically diseased hairs.—*Brit. Med. Journ.*, Aug. 30, 1873.

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*Disease of the Heart from Over-exertion.*—There are few more interesting subjects in cardiac pathology than the so-called "spontaneous" enlargement of the heart. Many authors have gone so far as to deny *in toto* the occurrence of uncomplicated hypertrophy or dilatation of the heart or of one of its ventricles; but their position has now for some time been untenable as was especially pointed out by Dr. QUAIN in his recent lectures on "Diseases of the Muscular Walls of the Heart." We have now before us a contribution of no less than nineteen cases of the kind, observed by Frantzel in soldiers who had taken part in the Franco-Prussian war (*Virchow's Archiv*, 1873, vol. lvii. p. 215, and *Centralblatt*, 1873, No. 35). These patients were perfectly healthy at the commencement of the campaign, and began to suffer from cardiac symptoms for the first time during the course of the war. When they came under treatment at the end of the campaign they were found to be labouring under enlargement of the heart, without discoverable disease in any other part of the vascular system, in the lungs, or in the kidneys. Of the cases enumerated the left ventricle alone was hypertrophied and dilated in ten, the right ventricle alone in two, and both ventricles in three; and in two other cases dilatation alone of the one ventricle or the other was found. Frantzel accounts for the cardiac enlargement by the extreme fatigue and muscular exertion which the men underwent for months in the field. The increased pulmonary activity induced by the obstruction to the expansion of the thorax under the uniform raised the tension in the pulmonary artery, and caused dilatation with hypertrophy of the right ventricle; and in the same way a corresponding enlargement of the left ventricle was brought about by the severe muscular exertion generally, as well as by the contraction of the peripheral arteries during the cold of

winter. The occurrence of simple dilatation is accounted for by the extreme severity of the exertion in some cases, and by the proportionately less resistant power of the cardiac tissue in others, who were badly nourished under the circumstances of privation in which their disease commenced.—*Med. Times and Gaz.*, September 6, 1873.

*Syphilitic Meningitis rapidly cured by Iodide of Potassium.*—The symptoms were as follows: Persistent cephalalgia, contraction of the muscles of the nape of the neck, dilatation of pupils, alternate redness and paleness of the face, slowness of speech, groaning, contraction of limbs, vomiting, etc.; pulse 88 to 92; temperature normal. On the eighth day, a treatment, consisting of mercurial frictions, and from a half to one drachm of iodide of potassium internally, was begun, and then the latter remedy alone was employed; the amendment was most rapid after three days. The use of the iodide was suspended, as a trial, and the headache returned, but resumption of the remedy again removed it, and at the end of eight days the patient (a syphilitic woman), left the hospital entirely recovered.—*Lancet*, Aug. 2, 1873, from *Ann. de Dermatologie et de Syphiligraphie*.

*Cases illustrating the Endemic and Non-infectious Character of Diphtheria.*—Dr. W. CARR read a paper on this subject at the recent meeting of the British Medical Association.

The object of his paper was to support the following inferences: 1. When diphtheria breaks out in a family, attacking one or more of its members, the cause will be found in some local sanitary defect. 2. The family should at once remove from the infected house—a measure at once obligatory and preventive. 3. Imported diphtheria does not, as interpreted by the cases, spread in a family. Comparing the well-known histories of the spreading, by importation, of scarlet fever, etc., with diphtheria, we are forced, resting our conclusions on the cases narrated in this paper, to accept the teaching that diphtheria is neither infectious nor

contagious, but strictly a preventable endemic disease, whose extermination will be, in due time, one of the victories of sanitary science.—*Brit. Med. Journ.*, Sept. 6, 1873.

*Hemorrhage of the Pericardium, consecutive on Hemorrhage of the Left Ventricle.*—The above case was recently communicated to the Anatomical Society of Paris by M. DEANSART. It occurred in a woman of seventy, who, the very day of her death, seemed to enjoy perfect health. She had always been in good health. The results of the autopsy were briefly as follows: Pericardium distended by liquid blood; external aspect of large blood-vessels healthy; ecchymosis on the posterior wall of the heart, in the situation of the left ventricle; towards the centre of this ecchymosis there existed a very small aperture, admitting the end of a grooved sound, which penetrated thus into a cul-de-sac, extending obliquely into the thickness of the ventricular parietes; no alterations were found in the situation of the large bloodvessels on opening the cardiac cavities; not the slightest communication existed between the left ventricle and the pericardium; incisions made into the ecchymosis showed that the infiltration of blood extended deep into the ventricular walls, but a certain portion of the ventricular muscle, towards the endocardium, was free from infiltration; the muscle seemed quite healthy; heart of normal size; no notable deposit of fat. Marked lesions of the posterior coronary artery were discovered; the internal surface was intensely red; a reddish clot blocked up the artery; proceeding from the auriculo-ventricular artery there appeared a collateral branch, extending towards the seat of hemorrhage. This artery was whitish, deprived of blood, and no doubt had afforded the liquid which had brought on the hemorrhage. Doubtless there had been rupture of a little altered artery on collateral circulation being re-established after the obliteration of the posterior coronary artery. The anterior coronary was also altered, the walls being thickened, and the internal aspect being reddish; but it

was puerious. The case is interesting as showing the possibility of spontaneous and fatal pericardial hemorrhage, due to lesions of the coronary arteries, and independent of rupture of the heart or of the large vessels.—*Lancet*, Aug. 2, 1878.

*Forcible Rectification of In-knee.*—M. DELORE read a paper on this subject before the French Association for the Advancement of Science. In-knee is a common result of rickets and scrofula, which prevail so extensively at Lyons. M. Delore states it is principally due to exaggeration of the natural curvature of the femur and tibia, accompanied by great depression of the internal tuberosity. In 350 cases he has rectified it by forcible pressure under chloroform, continued until the periosteum is detached and the epiphysis is separated, as announced by a cracking sound. The position is maintained by a starch bandage, and in a month the cure is complete. No accident has occurred, but the operation should not be performed after the fifteenth year or on weak subjects.—*Med. Times and Gaz.*, September 6, 1878.

*Surgical Means for increasing the Growth of Bones.*—M. OLLIER read a paper on this subject before the Section of Medical Sciences of the French Association for the advancement of Science. The paper was founded on a series of experiments and clinical observations. He finds that where there has been arrest of growth of the long bones, impeding progression or causing deformity, he can induce increase of growth by producing a superficial exfoliation of bone by means of caustics. In an instance in which, after an arrest of growth of the radius had been followed by deformity of the hand consequent on the continued growth of the ulna, this was rectified by the removal and crushing of the cartilage of the latter.—*Med. Times and Gaz.*, September 6, 1878.

*Effects of Senna on the Urine.*—At the last meeting of the Paris Therapeutical Society, Professor GUBLER drew attention to a curious property in senna of colouring the urine in a peculiar manner. The

urine of persons who have taken senna becomes of an intense yellow colour with a green reflection, just like the urine in jaundice; but nitric acid shows that bile has nothing to do with this colouring. If a fragment of caustic potass be let fall to the bottom of a tube containing urine charged with senna, a magnificent purple colour is produced; but nothing of the sort takes place under the influence of potass in icteric urine. This colouring has been observed in all the patients who have taken senna whose urine has been examined—even where only half an ounce of the infusion or a black draught of the Codex has been administered. Urine loaded with senna is incapable of assuming the variable rose colour under the influence of nitric acid which normal urine always assumes. Infusion of senna itself treated with caustic potass assumes, to a certain extent, the purple colour. But the phenomenon is here far less marked, and M. Gubler believes that in this case a process goes on similar to that which occurs in relation to asparagus, turpentine, copaiba, etc.—a certain amount of oxidation taking place in the economy for the production of the peculiar odour of asparagus or the violet odour. With rhubarb M. Gubler produced a much less intense colour than with senna; but he suspects that the phenomenon in both cases is due to the chrysophanic acid, which is common to both the substances. After the absorption of the senna, the colouring of the urine may persist, even to the next day. M. Gubler observed that for the detection of bile in the urine he always employs nitric acid, which he thinks is far preferable to iodine. He referred also to a peculiar colour of the urine often met with in severe disease, furnishing a *feuilles mortes* colour, which may be easily mistaken for biliary colouring. The colour is really due to the superposition of a blue colour on the yellow; and at his clinic M. Gubler has often shown this blue colouring, which he has named provisionally “urinary indigose.” On isolating it by ether, he renders the liquid clear by bringing to its upper part a ring of a beautiful blue colour.—*Med. Times and Gaz.*, Aug. 30, 1878.



**Action of Nitrous Oxide.**—JOYLET and BLANCHE (*Archives de Phys.*, v. July, 1873, p. 364) have obtained the following results from their experiments on this subject. Chemically pure nitrous oxide will not support the respiration either of animals or plants, as they cannot decompose the gas. When breathed in a pure state by animals, it causes asphyxia and death, with all the symptoms usually occasioned either by strangulation or by the respiration of an inert gas, such as nitrogen or hydrogen. Nitrous oxide causes death in nearly the same time as these other asphyxiating agents. Nitrous oxide has no special anæsthetic action. The anæsthesia which it may produce when inhaled in a pure condition is only due to want of oxygen in the blood. Insensibility appears when the oxygen in arterial blood is reduced to less than 2 or 3 per cent. Arterial blood is then very dark, and contains 30 to 40 per cent. of nitrous oxide. Animals can live and show no alterations of sensibility while breathing mixtures of nitrous oxide and oxygen, in the same proportion as nitrogen and oxygen in air. The arterial blood then contains about 80 to 85 per cent. of nitrous oxide. Birds placed under a bell-jar filled with this mixture, behave exactly like those placed in a jar of the same size filled with air, and die after having exhausted the oxygen to a similar extent and formed a similar amount of carbonic acid. As nitrous oxide is an irrespirable gas and does not possess the anæsthetic properties which have been attributed to it, the authors conclude that its employment cannot but be dangerous, and ought, on this account, to be excluded from medical practice.—*Brit. Med. Journal*, Aug. 9, 1873.

**Sugar and Magnesia an Antidote to Arsenic.**—The *Mouvement Médical* relates various experiments conducted by Mr. CARL, with the result of showing that sugar, mixed with magnesia, may serve as an antidote in cases of poisoning by arsenious acid, in which cases, too, the internal use of the hydrated magnesia is most valuable.—*Lancet*, August 2, 1873.

**Typhoid Fever and Milk.**—An outbreak of typhoid fever in London, a description of which will be found in *The American Journal of the Medical Sciences* for October, 1873, and which is now happily near its end, has drawn special attention to the propagation of enteric fever by means of milk. From *The London Medical Record* (Sept. 3, 1873) we learn that at Brighthouse near Halifax, and at Wolverhampton, epidemics have been traced to the milk-supply. At the former place, as many as fifty cases of the disease have occurred, although the exact manner in which the milk became contaminated is not very clear. At Wolverhampton the numbers affected have been limited; but the origin of the milk-adulteration was, it appears, not difficult to find, as the water-supply of the farm was obtained from a sewage-poisoned well.

**Deaths from Chloroform.**—A lady died on August 20, at the house of a dentist in Brighton, while under the influence of chloroform. The necropsy disclosed fatty degeneration of the heart.

A death from chloroform is recorded in the last British Army Blue-Book by Surgeon J. L. ESKINE, M.D., of the Royal Engineers. The patient was being operated upon for removal of diseased tibia, the result of compound fracture, and was not under the influence of chloroform above one minute, when the failure of the heart's action was noticed. The necropsy showed a hypertrophied heart and a flabby condition of its muscular walls.—*British Medical Journal*, August 23, 1873.

**Propagation of Cholera.**—It is known that the Russian State authorities, with PELIKAU at their head, differ considerably in their conclusions as to the recent outbreaks of cholera in that country and eastern Europe from those of most other nations. They concluded that these outbreaks were not new importations, but were due to the seeds of the disorder having remained latent from former epidemics, even as far back as 1852. They have now sent to this country the evidence on which this opinion is founded—evidence which seems fairly irrefragable, and as a

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consequence of which we are fain to confess that in all probability cholera is now fairly naturalized as an endemic malady in eastern Europe. We had already been compelled to assent to the statement that cholera had become naturalized in Persia, but we were hardly prepared for the same disquieting fact as regards Europe; but that being so, all information as to the mode in which it spreads assumes an increased importance, and we have seen nothing of greater importance on the subject than an abstract of modern views on the subject by Professor Parkes in the appendix to the recently-issued Army Medical Report.

This deals at some length with the views of Pettenkofer, as recently enunciated by him in a somewhat modified form, in reply to adverse criticisms from Sander and Küchenmeister. There is no denying their importance, not only from the weight of Pettenkofer's authority, but from the influence they exercise on the minds of many, both in this country and abroad. They have materially modified modern research in the matter, and should they turn out to be wrongly founded, this influence must have been most pernicious. The foundation of Pettenkofer's theory rests on the assumption that the cholera contagium is mainly or entirely propagated outside the human body; and thus the malady, from his point of view, though readily carried by human beings, and in the main following the lines of human intercourse, is not, strictly speaking, contagious, but rather miasmatic. The quantity of this contagious matter, according to his views, undoubtedly tends to increase, but it does so in the surroundings of the individual, not in himself; and the most important of these foci of new growth is the ground itself; and on peculiarities of soil he holds that the development of cholera mainly depends. He rejects *in toto* the theory of propagation by drinking-water, which he says in many instances he has investigated was impossible. Shipboard has been selected as a telling instance, where neither soil nor ground-water could be imported into the case, and has by some been considered utterly fatal to the ground theory of cholera. This Pettenkofer does not admit,

and yet is compelled to acknowledge that cholera has broken out in ships in epidemic fashion, though it is most frequently brought from the shore. Here he tries to import some new factor into the case analogous to the ground on shore, but seems to fail. Direct contagion, without any interference on the part of the soil, seems to be only too well established, yet Pettenkofer rejects it entirely. Nevertheless, in all probability the ground has some influence, though what it is seems as yet not quite clear; nor does it seem to be exercised in all cases. It is always a misfortune if a man resolutely blinds himself to any side of a question save that on which he himself is intent.—*Medical Times and Gazette*, July 12, 1873.

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*The International Medical Congress*—

The third International Medical Congress will be held in Vienna, from September 1st to 8th, under the patronage of the Archduke Rainer, and the presidency of Professor Rokitsansky. The members of the congress will consist of delegates from states and from scientific bodies, and of medical men and naturalists, who shall have intimated their intention of being present to the general secretary, before the opening of the meeting. Discussions are appointed to take place on the following subjects. 1. Vaccination: reporters, Dr. Hebra, Dr. Auspitz, and Dr. Kaposi. 2. The prophylaxis of Syphilis, with reference to the Regulation of Prostitution: reporters, Dr. von Sigmund, Dr. Reder, and Zeiss. 3. Quarantine, with special reference to Cholera: reporters, Dr. Oser, Dr. Drasche, and Dr. Witlacil. 4. The Sanitation of Towns (especially sewerage and drainage): reporters, Dr. Innhauser, Dr. Böhme, and Dr. Gauster. 5. The formation of an International *Pharmacopœia*: reporters, Dr. Bernatzik, Dr. von Schrott, sen., and Dr. von Schrott, jun. 6. The Social Position of Medical Practitioners: reporters, Dr. Schneller, Dr. Benedikt, and Dr. Schlesinger. The congress will be held in the Jury Pavilion of the International Exhibition at Vienna. The first meeting will take place on September 1st, at ten A. M.—*British Medical Journal*, Aug 23, 1873.

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On the whole, there is very little in the book which either the student or practitioner will not find of practical value and consistent with our present knowledge of this rapidly changing science; and we have no hesitation in expressing our opinion that this eighth edition is one of the best handbooks on physiology which we have in our language.—*New York Medical Record*, April 15, 1873.

This volume might well be used to replace many of the physiological text-books in use in this country. It is much less bulky and far more readable than the larger text-books of Carpenter or Marshall. The book is admirably adapted to be placed in the hands of students.—*Bost. Med. and Surg. Journ.*, April 10, 1873.

Kirkes' Manual is sufficiently comprehensive and its price so reasonable that it has become the most popular text-book we have.—*Lond. Students' Journ. and Hospital Gaz.*, March 1, 1873.

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